DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505151	A. BUILDING _____ B. WING _____	09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASHMERE CONVALESCENT CENTER	817 PIONEER AVENUE CASHMERE, WA 98815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is a result of an unannounced Off-Hours Quality Indicator Survey conducted at Cashmere Convalescent Center on 09/10/13, 09/11/13, 09/12/13, 09/13/13, 09/16/13 and 09/17/13. The survey included data collection on 09/10/13 from 5:30 p.m. to 8:30 p.m. A sample of 31 residents was selected from a census of 55. The sample included 32 current residents and 1 former and/or discharged resident. The survey was conducted by: [redacted] RN [redacted] RD [redacted] RN [redacted] RN [redacted] RN The survey team is from: Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597 Robert Bottering 9/27/13. Residential Care Services Date	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

10-15-2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 174 SS=E	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all residents who could use a phone had an ability to make calls without being overheard. Findings include but are not limited to: During the survey, telephone conversations were able to be heard when the surveyor walked past. Resident #1. On 09/13/13 at 1:00 p.m., Resident #1's family member stated the resident had no privacy when talking on the phone with her. The resident had to be taken across the hallway to use that phone and it was so noisy at times because of the nurses' station that it was hard for the resident to hear; their conversation "is not easy because of that." She stated if the facility had a portable phone then the resident could use it in her private room. When interviewed on 09/17/13 at 11:00 a.m., Resident #1 stated she did talk with her family on the phone in the hall and it was hard to hear. She wanted to use a phone in her room so she did not need moved into the hall for the phone calls. Review of the current care plan noted a problem with mild hearing loss requiring the phone volume to be turned up so the resident could hear the conversation. The plan also noted the resident's	F 174	POC for annual QIS ending 9/17/13 F-174 –The Right to make phone calls without being overheard A phone will be made available in the facility library/chapel a room which can be closed for privacy and which is located in an area where the noise levels are minimal. The Assistant Administrator will assure continued compliance of this finding Corrected 10/25/2013	

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F 174	Continued From page 2 family member usually called at 6:45 p.m. Resident #21. On 09/10/13 at approximately 7:30 p.m., she stated the phone in the hall was not private. On 09/17/13 at approximately 10:00 a.m., Staff Member C revealed the locations of the phones were in the hallways, lobby area and in an open alcove across from the laundry. She stated there were no private or portable phones available to the residents. The phone in the alcove was across from the laundry where noise created by the laundry machines was overheard with a potential to make it hard to hear a conversation.	F 174	F-241-DIGNITY AND RESPECT OF INDIVIDUALITY HOW THE FACILITY WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT(S); PRIVACY-Resident #13-A privacy curtain is placed in front of the door of room 313 to ensure visual privacy. ODORS- Resident # 27- "Remove all soiled linens and any personal items that are soiled with urine from my room every shift" was added to care plan. Clothing hamper was removed from room as this resident has her laundry done by the facility. The Resident Care Director will problem solve with resident for incontinent product that she will be willing to use and update care plan as indicated. Resident # 32 was assisted to her bed where incontinent care was provided at 1700 and again at 1904 per NAC documentation. She was parked outside of rooms that may have smelled of urine	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure full visual privacy for 1 of 1 resident (#13) observed during care; promotion of dignity in the assisted dining room for 4 of 12 residents (#28,31,44,71); and/or preventing 2 of 11 incontinent residents (#27,32) from smelling of urine. This caused a lack of dignity and respect for these residents. Findings included, but are not limited to:	F 241		

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F 241	Continued From page 3 PRIVACY: Resident #13. On 09/12/13 at 3:00 p.m., she was in a private room setting without a privacy screen or curtain. She stated she did not use the bathroom toilet but used the commode. She needed assistance for transfering with the mechanical lift onto the commode. Upon requesting to use the commode, nursing assistants transferred her to it, which they had placed in the entry of the room. The nursing assistants left the room for the resident's privacy. During the time the resident was seated on the commode, the door was open twice for a Licensed Nurse and twice for nursing assistants. Each time, the resident was visible from the hall. Following the use of the commode, the resident's pants were removed and she was raised in the mechanical lift for perineal/rectal care to be provided. The resident was then transferred over to the bed to lay down for a skin assessment of her "bottom." Again, when the door was open for staff, she was exposed. When the Licensed Nurse entered to offer medications, the resident said "no" as she was sitting in the mechanical lift sling on the bed and without pants. The resident did not have the means of withdrawing from public view during personal cares/services. ODORS: Resident #27. Diagnoses included [redacted] and [redacted] The 06/20/13 care plan identified she was frequently incontinent. She	F 241	DINING ROOM-Resident # 44-The plastic cart cover will be stored out of reach of residents to prevent them from touching it. Resident #71-"I can be loudly vocally demanding so do not serve me until you can stay and assist me" added to her care plan. Resident # 28-Staff member C, the NAC who returned tray to resident # 28 states she did not realize that Res # 31 had touched the food and was counseled regarding doing this and states understanding of dignity and infection control issues with this action. Resident # 31-updated care plan to reflect "I may try to take food from other residents trays so do not seat and serve me until you are ready to stay and assist me with my meal." Resident # 54-One table was removed from the Vista Dining area to open up the space which will prevent the crowding that contributed to her falls. HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:	

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F 241	Continued From page 4 was to be toileted per "routine care protocol" (every two hours). She was to wear incontinent briefs. On 09/10/13 at 12:00 p.m. the resident stated she could "smell something" but she did not know what it was; "it bothers me." It was noted the resident and/or her room had an odor of strong urine. Also, the resident's toilet bowl was smeared with stool and yellow stains. On 09/10/13 at approximately 12:30 p.m., Staff Member J stated the staff were aware of the resident's urine odor. She stated the resident refuses to take a bath. The room and linen were cleaned as often as she needed. During the on-site survey of six days, the resident's room was noted to have a strong urine odor each day. On 09/16/13 at 3:15 p.m. the resident's room was noted to smell of urine. When interviewed at that time, nursing assistant, Staff Member I, stated staff can wash down the bed with a product should the linen be wet and exchange her rug to help with the smell. At 4:15 p.m. Staff Member I went into the room and changed linen and clothing, then removed the receptacle with the soiled clothing. Following this, the room no longer smelled of urine. On 09/17/13 at 9:00 a.m. the Housekeeping Supervisor, Staff Member W, stated the procedure for cleaning the resident's room was for nursing assistants to remove the linen and and clean the mattress and frame weekly. The housekeeping staff were to clean the bathroom daily.	F 241	PRIVACY-Environmental round was completed and revealed some other rooms with missing privacy curtains. Curtains were placed to block the view from the door in all rooms. ODORS- West Hall nurses in-serviced on need to follow up on unpleasant odors by supervising NAC staff to provide appropriate care and follow up with Resident Care Director to enlist assistance for care planning for ongoing problems with odor. DINING ROOM-The food cart cover will be stored out of reach of residents. We will continue to monitor placement of tables and space in the Dining rooms. MEASURES THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THE PROBLEM DOES NOT RECUR: PRIVACY-The facility will do monthly environmental rounds to include making sure all rooms have adequate privacy curtains. ODORS-Odor problems reported to Resident Care Directors will be discussed at bi-weekly stand up meeting	

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F 241	Continued From page 5 Although the resident required assistance for her personal care and cleaning of her room, the resident and/or her room continued for six days to smell strongly of urine of which the staff were aware. Upon being informed of the smell on 09/16/13 by the surveyor, the nursing assistant then changed linen and removed the receptacle which removed the urine odor for that period of time. Resident #32 Admitted with diagnoses including [redacted] (partial or total loss of the ability to [redacted]). The comprehensive assessment dated 06/27/13 revealed she had severely impaired cognition and was incontinent of bowel and bladder. Review of the care plan for Resident #32 noted the resident was no longer able to communicate her needs, and staff were to monitor her expression and body language for indications of problems. She was totally incontinent. She required extensive assistance with all cares. On 09/10/13 at approximately 6:50 p.m. Resident #32 was sitting in her wheelchair in the hallway. Passing the resident, there was a stong, pungent urine odor noted. Observation for 35 minutes revealed staff passed by her mulitple times without assisting the incontinent resident. DINING ROOM: The Vista Dining Room was an assisted dining for twelve residents with impaired cognition. These residents required a specialized dining environment that would allow them to focus on	F 241	so can enlist help from housekeeping if needed and to enhance problem solving. DINING ROOM-Bi-monthly assessment of placement of table and space in all Dining rooms will be completed by DNS, her designee and/or Resident Care Directors.. HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: PRIVACY-QA report on environmental rounds to include appropriate placement of privacy curtains will be completed by the Executive Housekeeper. ODORS- QA report on any persistent odors and solutions applied will be completed by the Executive Housekeeper. DINING ROOMS-QA report on changes to seating and table arrangements in all dining rooms based on bi-monthly assessments and report at QA meeting as to effectiveness and function in the dining rooms.	

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F 241	Continued From page 6 their eating. On 09/10/13 at approximately 6:00 p.m. the Vista dining room was noted to be crowded with tables in close proximity. Four tables were against the walls with adjustments made to those tables and chairs to get the residents postioned. Two tables were central. There were several residents in wheelchairs with leg extenders. There was a television on that displayed a snowy picture without sound (potentially causing glare and distraction for cognitively impaired residents). Two nursing assistants were assigned to the dining room. Resident #44. Observed picking and handling a large, flexible plastic cover for the tall food cart that staff had placed on a chair near the resident. Staff Member J, a nursing assistant (NA), was trying to get the plastic cover away from the resident by pulling the resident's wheelchair away. At the same time, Staff Member J was grabbing the plastic cover, pulling it from the resident's hands while the resident pulled back. Concurrently, Resident, #71 was yelling across the table that "no one helps you to learn how to eat around here. I am dropping my food and they do not give a crap." At approximately 6:30 p.m., Staff Member S, a NA, asked the resident to be patient and help was on the way. The resident continued to yell and eventually was removed at 6:40 p.m. Staff Member J, who instructed staff to wheel the resident around the outside of the building to help calm her. The resident had not eaten her meal but dropped all of her food on the floor as she attempted to eat independently. Another resident was making grunting sounds	F 241	DATE WHEN THE CORRECTIVE ACTION WILL BE COMPLETED: 10/25/2013 TITLE OF PERSON RESPONSIBLE TO ENSURE CORRECTION: DNS, RESIDENT CARE DIRECTORS, STAFF DEVELOPMENT, MAINTENANCE AND EXECUTIVE HOUSEKEEPER.	

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F 241	Continued From page 7 and pointing to Resident #31. Resident #31 had taken Resident #28's tray of food and was eating it with her hands. Staff Member S then took the tray back from Resident #31 and returned it to Resident #28 without obtaining a new food tray. Staff Member S stated that Resident #31 was usually served last because she needed assistance. (Although it was noted that many of the other residents also required assistance to eat.) Resident #31 continued to wheel herself in the Vista dining room reaching for the other residents food trays. On 09/10/13 at approximately 6:45 p.m., Staff Member J stated that the residents on the 400 hall who eat in the Vista dining room were "residents with dementia and have behaviors." According to the residents care plans (#28, 31, 44 and 71), they were assigned to eat their meals in the Vista dining room with assistance from staff. Additionally, Resident #54 was admitted with impaired cognition and language deficit. The 07/16/13 assessment (MDS) identified the resident had disorganized thinking with trouble concentrating. Her current plan of care noted she was at risk for falls as she was unaware of safety needs and had gait/balance problems. The Incident Log reported the resident had falls in the Vista dining room. Two of three falls recorded were during the evening meal between 4:30 to 5:00 p.m. The documented fall investigations revealed: On 08/24/13 at 4:30 p.m. the activity aide had turned her back when the resident fell trying to	F 241		

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F 241	Continued From page 8 pick something up off the floor. The environment was described as "crowded..." On 09/05/13 at approximately 5:00 p.m., the resident was standing, hanging onto the table when another resident moved the table causing the resident to fall. The environment was described as "crowded."	F 241	F-246-REASONABLE ACCOMODATION OF NEEDS/PREFERENCES HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accommodate 1 of 1 resident (#29) who preferred eating in an independent dining setting and failed to accommodate 4 of 6 residents (#8,13,29,35) who were capable of communicating their bathing and caregiver preferences, which were not being met. This caused one resident to remain in her room without companionship during meals, thus lessening the enjoyment of the meal. Further, it placed residents at risk for a lessened quality of life. Findings include: Resident #13. On 09/12/13 at approximately 3:00 p.m. she was seated in a wheelchair and said her "bottom hurt a lot." She requested nursing	F 246	Resident #13-This resident has always had female caregivers for peri-care per her preference per her care plan. She does not prefer to have female nurse or doctor. "I have always had a male doctor." She currently is seen by Dr. Chad McBride per her preference rather than our routine gerontologist who rounds weekly and is a female. The male who is routinely assigned to the hall she resides on is never assigned to her. She is always assigned to a female caregiver who is also working the same area of the facility. Staff member K, the male nurse who attempted to dispense meds while she was in a state of undress and /or on the BSC and then documented they were refused was counseled regarding appropriate times to dispense her medications and approach. He does not remember that she was not dressed when sitting at the side of the bed and stated that she was short with her	

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F 246	Continued From page 9 assistants to place her on the commode, after which her wet pants were removed. The Licensed Nurse, Staff Member K, partially entered the room with medications, but she was using the commode and he withdrew. The nursing assistants helped the resident from the commode to the bed. She was seated on the beside with no pants prior to be re-dressed. Staff Member K entered again and asked if she wanted her medications. The resident said "no" and he left. Staff Member K was then observed documenting it as a refusal of medications (although it was not a convenient time for the resident to receive medications due to lack of dress. Thus, she missed her medications.) The resident was positioned on the bed for a nurse to look at her sore bottom but refused to have the male nurse look at it, requesting a female. Nursing assistants, Staff Members D and E, both stated that the resident preferred females as caregivers. They were regularly assigned to another hallway but lack of staff had required they assist in the resident's hall. When interviewed on 09/12/13 at approximately 4:00 p.m. Licensed Nurse, Staff Member Z, stated the resident did not like males to provide care or even assess her. The nurse said the resident had even refused a male physician's assessment of her body. However, it was noticed the facility did not provide for the resident's preferences assigning a male as a primary nurse. Also, a male nursing assistant was usually assigned to that resident's	F 246	response to him and said "no" when he approached with her medications. Resident #29- The change in Resident # 29's dining assignment was an appropriate change in her care plan as it was an accurate reflection of her declining condition, however, the psych-social aspect may have been better managed with more explanation of the nursing concerns and support for this residents desire to eat with people of her choosing. Nursing assessments via "alert charting" from 9/13/13 through 9/17/13 of her eating function and psychosocial distress revealed she was able to maintain alertness and eat appropriately. Her dining area was changed back to the Pioneer Diner on 9/17/13. Ten days later her condition deteriorated again and she was transferred to the hospital where she passed away. Resident # 8-On 9/18/13 this resident stated that she had never had two showers a week but would prefer to do that. Her care plan was immediately updated to have showers in the AM on Thursdays and Sundays per her stated preference.	

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F 246	Continued From page 10 hallway as noted multiple days of the survey. Resident #29. Admitted with diagnoses of [redacted] 2012. On 09/12/13 at 1:00 p.m., the resident stated she was used to eating in the Pioneer dining room which was for independent residents. She stated because she took too long to eat her meals, now she had to eat in her room. When she had been the last one in the dining room, she had turned off the lights and locked the door to try and help the staff. She said she liked eating in that dining room with others and it "hurt my feelings" and upset her when she was told she could not (the resident had tears in her eyes during the conversation). When she asked the nursing director about it, she was told she could go back to that dining room when the nurses said it was okay. On 09/12/13 at approximately 1:15 p.m., while standing in the Pioneer dining room, Staff Member M said she acted as a hostess for that dining room. Residents eating in the Pioneer dining had had to be safe eating and not require help. She stated Resident #29 was not safe and would fall asleep while eating. It took Resident #29 over an hour to finish her meal and that was too long as staff had "other things to do." Also, the resident would mix her food together which she could not then eat. It upset other residents to watch her. Staff Member M locked the door after the last resident left. When asked the reason for the locked door, she stated it was because they had to set up the dining area for dinner and there were knives and forks on the tables.	F 246	Resident # 35 was offered to get into a tub with staff assistance which she accepted. She was able to get in and out of the tub on North hall and took a half hour soak. Per discussion with her, her care plan is updated to tub baths alternating with showers. HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS: CAREGIVER PREFERENCE-We will continue to assess and communicate to staff via the care plan/Kardex resident preferences for gender of caregivers. BATHING-Social Services will interview all interview able residents regarding their bathing preferences. The questions ask will be "How often would you like to bathe?" "Would you prefer a tub bath or a shower?" "What day of the week would you like to bathe?" and "What time of day do you prefer to bathe?" With this information the Resident Care Directors can update the bathing schedule and resident care plans to reflect their preferences. DINING ASSIGNMENT-Any time residents have changes in dining room	

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F 246	Continued From page 11 On 09/13/13 at 11:45 a.m., the Social Service Director, Staff Member V, stated the resident scored well on her mental assessments for cognition and mood so no issues were identified. She said there were no current change in the resident's behavior/cognition and she was not on antipsychotic medications. When asked why the resident was eating in her room rather than her preferred independent dining setting, Staff Member V stated she was not aware of the dining room change. On 09/13/13 at 11:00 a.m., the resident was seated in the hallway. She asked if she could eat in the dining room again; she wanted to go back to the dining room as soon as possible. On 09/17/13 at 1:30 p.m., the Activities Director, Staff Member O, stated she had initiated the change from the Pioneer dining room as the resident was "socially inappropriate;" she was playing in her food. She stated it was possible for interventions to be tried in how the resident's food was presented to her that would help prevent the mixing of food. The fact she took so long to eat or fell asleep was not an issue. She stated the resident usually was fine, but had changes in cognition at times that seemed to cause confusion and then she would put things like hot chocolate in her oatmeal. Resident #8. On 09/10/13 at 10: 56 a.m., the resident said that there was no choice in the number of showers they could have in a week. The resident stated "They tell me once a week for a shower...that is what all of us get. I would like to have a bath more than that. It's the rule...I would like it at least twice a week. My showers	F 246	assignments they will be placed on "alert" status for three days for nursing to document their response to this change. MEASURES THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR: CAREGIVER PREFERENCE-We will continue to discuss any resident concerns or grievances at bi-weekly stand up meeting and address concerns as they are brought up. BATHING-The bathing schedule will be altered to address all preferences discovered during resident Interviews regarding bathing preferences. DINING ASSIGMENTS-Daily review of "24 hour report" in the EMR to pinpoint any dining area concerns will be completed by DNS, SS and Resident Care Directors. Nursing charting guidelines updated to include alert charting for dining room changes. HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED:	

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F 246	Continued From page 12 are early on Thursday morning but they change over time. In the past I had showers twice a week but they quit doing that. I asked the staff if I could have two bathes a week and they tell me they do not have time." The resident assessment dated 08/29/13 did not indicate resident's preference for the number of showers the resident would like weekly. The care plan revised 09/05/13 for bathing interventions documented "I require physical assistance to shower/bathe weekly. Set-up to wash and to wash upper body. Total assist to complete." On 09/12/13 2:09 p.m. Staff Member O, the Activities Director, stated that she "completes the assessment of preferences but had not asked about how many times a week a resident would like a bath. I do not always ask about preferences every time I do an assessment." On 09/12/13 at approximately 2:30 p.m., Staff Member B, stated "that they offer one bath a week unless the residents request more or family request more frequently." Resident #35. On 09/10/13 at 6:39 p.m. the resident stated that "there was no choice but to have a shower and I would really like a tub bath. They say I can't have one I need help getting in the tub. I certainly would enjoy having one. I use to swim and enjoyed the water." The resident's plan of care dated 05/22/13 under interventions for self-care performance deficit does not indicate any bathing preferences. On 09/10/13 at approximately 1:00 p.m. located on the west end of the building an oval old	F 246	CAREGIVER/DINING AREA PREFERENCES-QA report with focus on resident caregiver and dining area preferences will be completed at least quarterly and presented at QA meeting by Resident Care Directors. BATHING-QA report with focus on resident bathing preferences will be completed at least quarterly and presented at QA meetings by SS. DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED: 10/25/2013 TITLE OF PERSON RESPONSIBLE TO ENSURE CORRECTION: DNS, RESIDENT CARE DIRECTORS, SS DIRECTOR	

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F 246	Continued From page 13 fashion bath tub was positioned on the right far side of the bathing room. Adjacent to the bath tub was a small table and chair used as a desk and there was no plumbing hardware to the bath tub to make it workable. Staff Member R stated that "tub is not in use." On 09/10/13 at 7:00 p.m. on the north hallway a bathtub room with a bathtub was located on the left side of the hall. On 09/11/13 at 10:30 a.m., Staff Member B, stated that the bathtub on the north hallway was used by Physical and Occupational Therapy. It was too low and only available to residents that were able to get in and out of the tub with minimal assistance; they had to be able to sit down and get up from a sitting position. The facility did not allow the use of a mechanical lift for the bathtub. Therefore, the facility did not provide the opportunity for an immersion bath for the residents preferring that type of bathing.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain care equipment in a sanitary and comfortable manner for 1 of 2 mechanical lifts observed and 5 of 22 sampled residents wheelchairs (#1,13,29,42,58). This caused a lack	F 253	F-253 Housekeeping and Maintenance This Survey finding has been reviewed with the Housekeeping Supervisor and the Maintenance Supervisor. Housekeeping has taken over the responsibility for regular wheelchair and lifts cleaning and has adjusted their schedule to accommodate this. 1. The 300 wing lift has been cleaned. All other facility lifts were inspected and clean as necessary. The Executive Housekeeping will monitor this survey finding for continued compliance. Corrected 10/25/2013 2. Resident 1's broken arm rest has been replaced. Maintenance has inspected all the wheelchairs for broken or failing arm rests. The Maintenance Supervisor will	

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F 253	Continued From page 14 of a sanitary and homelike environment. Findings include: On 09/12/13 at 3:00 p.m., the mechanical lift on the 300 hallway was heavily soiled with brown spots in a spattered pattern over the lower and main metal frame. Upon wiping a small area with a wet paper towel, the brown spots were able to be removed. On 09/17/13 at 11:00 a.m., the same mechanical lift on the 300 hallway remained soiled 5 days later. Resident #1. On 09/17/13 at 12:00 p.m., Resident #1 sat in her wheelchair with her right forearm resting on a broken arm rest. The front portion of the plastic arm rest was missing leaving a ledge that the resident described as "rough." When felt, although it was not sharp, it was without a smooth edge. Her forearm came to rest directly on the broken edge. Further, Resident #1's wheelchair was soiled on the lower metal parts. Resident #13. Seated in her wheelchair on 09/12/13 at 2:50 p.m., she stated her wheelchair was "worn out." It was noted with foam padding exposed on the torn left arm rest. The structure of the wheelchair was soiled with unknown particles. Further, the baseboard material near the doorway was coming away from the wall. Debris was underneath the baseboard. Resident #29. On 09/12/13 at 1:00 p.m., the resident's wheelchair was soiled on the frame	F 253	monitor and maintain continued compliance of this survey finding. Corrected 10/25/2013 3. Resident 1's wheel chair has been cleaned. Facility wheelchairs have been placed on a regular cleaning schedule. Our Maintenance Repair Request Form has been revised to include needed housekeeping requests. The Executive Housekeeping will monitor this survey finding for continued compliance. Corrected 10/25/2013 4. Resident 13 foam padding and arm rest were replaced. Maintenance has inspected all the wheelchairs for broken or failing arm rests. The Maintenance Supervisor will monitor and maintain continued compliance of this survey finding. Corrected 10/25/2013 5. Baseboard has been re-secured. The Maintenance Supervisor has inspected the facility for other incidents of	

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F 253	Continued From page 15 and with a brown sticky substance on the brake handle. There was silver duct tape wrapped where the insert for the leg extensions on both sides of the wheelchair. The duct tape made the surface un-cleanable. Resident #42. On 09/10/13 at approximately 2:10 p.m. the resident's wheelchair was parked in the resident's room. The seat of the wheelchair had dry particles on it. Several of the particles were pea sized. Resident #58. On 09/16/13 at approximately 9:15 a.m. she was wheeling up and down the hallway in her wheelchair. There were dry and grimy appearing particles on the lower parts of the wheelchair. On 09/17/13 at approximately 11:15 a.m. the wheelchair continued to have dry and grimy appearing particles on the wheel and on the brake handle.	F 253	loose baseboard. Maintenance has inspected all the wheelchairs for broken or failing arm rests. The Maintenance Supervisor will monitor and maintain continued compliance of this survey finding. Corrected 10/31/2013 6. Resident 29 is no longer in this facility. Facility wheelchairs have been placed on a regular cleaning schedule. The Executive Housekeeping will monitor this survey finding for continued compliance. Corrected 10/25/2013 7. Residents 42's wheelchair has been cleaned. Facility wheelchairs have been placed on a regular cleaning schedule. The Executive Housekeeping will monitor this survey finding for continued compliance. Corrected 10/25/2013 8. Residents 58's wheelchair has been cleaned. Facility wheelchairs have been placed on a regular cleaning schedule. The Executive Housekeeping	
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure comfortable sound levels were maintained in the facility for residents located in the 300 hall. This caused distraction and inability to be heard during activities of daily living and/or conversations. Findings include: When interviewed on 09/12/13 during the	F 258		

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F 258	Continued From page 16 afternoon, the fan in the 300 hallway ventilation system had a loud, rattling noise heard throughout the hallway and in resident rooms. When interviewed in her room on 09/12/13, Resident #59 stated she heard the hallway noise but she was not complaining because it was for another resident in the area who needed to be kept cool. She entered the hallway from her room to speak further with the surveyor, but both found it was hard to communicate due to the noise. On 09/12/13 at 1:00 p.m., the resident in room 308 stated the noisy hall fan bothered her as it was located outside her room; "I don't like all the noise." On 09/12/13 at 12:54 p.m., Resident #29 stated the "swamp cooler is loud down the hall and makes a loud noise. I have to turn my TV on at night to sleep." On 09/17/13, Staff Member T stated the system was a swamp cooler.	F 258	will monitor this survey finding for continued compliance. Corrected 10/25/2013 F-258 – Comfortable sound levels. The Maintenance Suppervior has repairted the swamp cooler on north wing and has winterized it for the season. The maintanence Supervisor will assure that this finding remains in compliant. Corrected 10/14/2013	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 312	F-312-ADL CARE PROVIDED FOR DEPENDENT RESIDENTS HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT: Resident # 14 had her nails cleaned using an orange stick by staff member P in the early AM of 9/17/13. Resident # 58-"I will sometimes allow nail care first thing in the AM with my morning coffee-try to clean and trim my nails daily at this time" was added to care plan. Other avenues of getting this	

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F 312	Continued From page 17 review, the facility failed to provide good grooming/ personal hygiene services for 2 of 16 residents (#14,58) who were unable to perform activities of daily living by themselves. Residents #14 and 58 were not provided nail care as needed to prevent soiling under their nails. Findings include: Resident #14. Admitted with diagnoses of [redacted] The comprehensive assessment (MDS) dated 05/30/13 identified the need for one person physical assistance for personal hygiene (including nail care). However, three months later on the 08/28/13 her annual MDS assessment, identified her as needing supervision with "setup help only" for her personal hygiene. Documentation included, "She is able to perform her own personal hygiene with set up at sink...These deficits are due to the progression of her disease process, Alzheimer's...She believes she can do more for herself than she actually can." The current care plan documented the need for 'personal hygiene' required the resident to be set up and supervised to wash her face, hands, brush her teeth and comb her hair. It further idenified she was a diabetic and nail care was to be done by licensed staff only. She was also "...resistive to care, including showers." There were no specific instructions for cleaning under the nails to remove ongoing soiling substances that was evident during all the days of the on-site survey. On 09/10/2013 at 11:38 a.m., the resident was seated in her wheelchair holding her head in her hands. She was unable to provide answers to questions. Her nine fingernails (she was missing	F 312	resident to willingly participate in doing some activity that would involve her hands and soap and water are being explored to also add to her care plan. HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS: The bath aid will continue to provide weekly nail trimming and cleaning to all resident who are not diabetic. She will report any refusals of nail care to the nurse for follow-up. NAC's will continue to monitor all residents for clean nails with AM and HS care and attempt to clean nails as needed using orange sticks. All refusals of nail care will be reported to the nurse for follow up. MEASURES THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR: A standard "alert" added to EMR/POC to make it easier for NAC's to communicate resident's refusals of needed nail care.	

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F 312	Continued From page 18 one partial finger) had a dark substance under the nails. On 9/13/13 and 09/16/13, the resident continued to have a dark substance underneath her finger nails. When interviewed on 09/16/13 at 2:30 p.m., Staff Member K, the Licensed Nurse, stated he had a nursing order on the medication administration record (MAR) to trim the resident finger and toe nails twice a month. He provided the MAR with the order and initials that the nail care was being done by licensed nursing staff. However, he stated that the licensed staff did not provide daily cleaning of the finger nails as needed. When interviewed on 09/16/13 at 2:45 p.m., the nursing assist on day shift, Staff Member P, stated he cleaned under the resident's nails with orange sticks. He stated he did this care once a week if she would let him. He could not recall the last day he had cleaned her nails or when he would do it again. Resident #58. Admitted on [redacted]/12 with diagnoses including [redacted] Review of her 07/30/13 comprehensive assessment (MDS) revealed she wandered in her wheelchair on a daily basis and displayed physical and/or verbal behaviors directed toward others. The assessment noted that these behaviors did not place the resident at significant risk of injury or significantly interfere with care. Further, the assessment revealed she required extensive assistance from staff with personal hygiene tasks.	F 312	HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: QA report with focus on clean fingernails and toenail/podiatry care needs will be completed at least quarterly and presented at QA meeting by Resident Care Directors. DATES WHEN THE CORRECTIVE ACTION WILL BE COMPLETED: 10/25/2013 TITLE OF PERSON RESPONSIBLE TO ENSURE CORRECTION: DNS, RESIDENT CARE DIRECTORS	

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F 312	Continued From page 19 On 09/10/13 at approximately 9:00 a.m., the resident was observed in the hallway, self-propelling in her wheelchair. Her hair was matted and tangled. Her fingernails had dark matter underneath the nail. The resident was not able to answer questions due to confusion from cognitive impairment. On 09/12/13 at 3:45 p.m., resident was wheeling her wheelchair up and down the 300 hallways. Her hair was combed out and braided. Her fingernails continued to have dark matter underneath each nail. On 09/16/13 at approximately 2:45 p.m., Staff Member I, a Nursing Assistant, offered Resident #58 a sandwich. On 09/17/13 at approximately 10:00 a.m., Resident #58 was in the hallway in her wheelchair. She had a partially eaten sandwich in one hand. Her fingernails and hands were dirty. Review of the care plan for Resident #58 revealed staff was to offer extensive assistance with washing her hands. Nails were to be trimmed and cleaned as needed. The care plan also noted the resident was resistive to care, with interventions for the resistance including re-approaching her later, to explain all care. On 09/12/13 at 2:20 p.m. Staff Member X, a Registered Dietitian, stated that Resident #58 did not eat in the dining room because she had trouble sitting still. She stated they planned a finger food menu for her and the finger foods are offered to her "on the fly" while she wheels about the facility.	F 312		

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F 312	Continued From page 20	F 312		

On 09/16/13 at 2:45 p.m. Staff Member I, nursing assistant, stated that Resident #58 is resistive to care and her fingernails are difficult to keep clean because she scratches herself.

On 09/16/13 at 3:10 p.m. Staff Member Y, a licensed nurse, stated they try different approaches to provide care to the resident. If she resisted care, the approaches included re-approaching her later, attempting the care in the mornings because she is usually more receptive to care at that time of day, having women provide the care instead of men and using staff people she especially likes.

On 09/17/13 at 9:15 a.m. Staff Member B, the Director of Nursing, stated Resident #58 often does not allow her hands and nails to be cleaned. The technique they tried was to re-approach and re-approach.

On 09/17/13 at 12:30 p.m., Staff Member J, a Licensed Nurse, stated she had learned the resident will accept care in the morning when she first got out of bed and into her wheelchair. She liked coffee and, while drinking it, Staff Member J had been able to clean her nails, "at least one hand." She stated she had not been able to do this for the resident that morning. Staff Member J acknowledged it was not on the care plan nor was it routine care provided by her.

Resident #58 resisted care and staff had tried approaches that had the potential to increase the amount of personal hygiene that could be provided. However, these approaches were not implemented consistently and the resident did not receive appropriate hand hygiene and nail cleaning. This failure had the potential to

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F 312	Continued From page 21 negatively impact her health as she frequently ate food with her hands and scratched her skin with her fingernails.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify environmental hazards and individual resident risks for accidents with residents eating in the main dining room. Further, in 4 of 27 resident rooms (room #s 405, 408, 412, 415) observed, the facility failed to keep electrical cords in safe repair, placing residents at risk of non-functioning equipment with potential for injury. Findings include: MAIN DINING ROOM: Resident #76. On 09/05/13 'Incident Investigation' revealed he had slid from his wheelchair while self-propelling to a table where he routinely sat. Documentation revealed when he was questioned about the fall he had stated to the staff that "I was trying to move that chair." The investigation reported noted "attempting to move other chair in path to table for meal." The fall was caused when he was reaching forward	F 323	F-323 Free of Accident Hazards Main Dining Room; The main dining room has been completely rearranged to provide clear access for residents trying to move independently throughout that room. The Assistant Administrator will monitor this survey finding for continued safety compliance. Corrected 9/19/2013 Electrical Exposed electrical plugs in room 405 and 408 have been repaired. Routine inspection of the facility found several other plugs in need of repair and were repaired. The Maintancance Supervisor will make regular room evalutations to identify maintenance issues. The Assistant Administrator will monitor this finding for continued compliance. Corrected 9/19/2013	

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F 323	Continued From page 22 beyond his balance limit partially due to his unsteady movement and tremors. Resident #12, seated in a wheelchair at a small square table with his back to the wall, attempted to self propel out of the dining room. Unable to move in one direction due to residents blocking his way between tables, he kicked the tall, wheeled tray cart out of the way. He then proceeded to self-propel past it and the table. On 09/10/13 at approximately 6:30 p.m., an anonymous resident was observed in the main dining room trying to self-propel his wheelchair. His wheelchair had leg extensions elevated at approximately a 45 degree angle. He was unable to pass by the piano bench with an empty meal tray sitting on the bench, but hanging off of one side. In order to pass, he had to kick the piano bench/tray out of his way with his left foot. He then had to back up and rearrange his positioning and direction before he was able to achieve his goal of leaving the dining room. Additionally, on 09/10/13 during the evening meal the tables were pushed together for residents to be seated in two separate areas of the room. The resident at the end of one table had her back to the wall and only one way of exiting her table by self-propelling between two long tables. Resident #36 was unable to speak when asked questions. When finished with her meal, she attempted to self-propel her wheelchair out of the room. However, the other residents seated at her table and the next table blocked her way. Unable to verbalize the need for help, she raised her hand until noticed by a nursing assistant. The nursing assistant then moved another resident, who was still eating her dinner, completely away	F 323		

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F 323	Continued From page 23 from the table so Resident #36 could leave. The main dining room was situated with tables and chairs that placed residents at risk of injury while attempting to enter and/or exit the room. ELECTRICAL: On 09/10/13 at approximately 2:15 p.m. the electrical cord that powered the bed in Room 405 was observed to be frayed. Electrical wires were visible near the plug of the cord. Black tape was wrapped around the cord below the visible wires. The plug was connected to an electrical outlet. The second bed in Room 405 had the electrical cord that powered the bed in Room 405 had visible wires near the plug of the cord. The covering for the wire was frayed and pulled away from the plug, which was connected to an electrical outlet. On 09/11/13 at approximately 9:00 a.m. the electric cord that powered the bed in Room 408 had exposed wires near the plug. The wire covering had frayed and pulled away from the plug. The plug was connected to an electrical outlet. On 09/17/13 at approximately 9:30 a.m., Staff Member T, the Maintenance Supervisor, stated he inspected other rooms and found two other frayed cords besides the above identified cords.	F 323	F-371 Food Procedure for Thawing Response to F-371: CCC State Health Survey of September 17, 2013 **Thawing Process:** Thawing of Ground Round: the cook indicated he had just turned the running water off prior to the licensor walking in and was inroute to get a container to put the meat in to prepare it for the meal. He also indicated he knew the stock pot of water was not tall enough for the 10 lb. chub of meat and had been flipping the chub over every 20 minutes for what he thought would be safer thawing. Thawing of the Non Dairy Topping: The dietary assistant realized after trayline started that she had forgotten to put the nondairy topping on the puddings for 4 or 5 servings. She took it out of the freezer and put it in the water just long enough to thaw a small amount for those specific servings. All this had to happen within a very short time – about 20 minutes. The licensor indicated to dietary management at the time that she was not concerned due to the small amount of topping needed. Dietary Management has contacted the Rich's Company on the safety of thawing their product. Attached is the response that it	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		

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F 371	Continued From page 24 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to prepare food under sanitary conditions. Failure to properly thaw foods and to adequately sanitize wiping cloths between uses placed residents at risk of food borne illness. Findings include: THAWING PROCESS: On 09/10/13 at 8:50 a.m., a ten pound plastic wrapped package of raw ground beef was in an approximately 3 gallon stockpot filled with water. The stockpot was in a food preparation sink. The meat was packaged in a cylinder shape, approximately 24 inches long and 6 inches in diameter. Approximately half of the package was immersed in the water. The portion of the package not immersed in water felt soft and was lukewarm to touch. No water was running into the stockpot or over the meat. On 09/16/13 at approximately 11:50 a.m., a package of nondairy pre-whipped dessert topping was in a stockpot. The package of dessert topping was approximately 12 inches long and in a pastry bag shape. The stockpot was in a food preparation sink. The stockpot contained approximately one inch of water and the package	F 371	is safe on the counter (indicating not under running water) for 30 minutes and then should be refrigerated after use. POC: The facility will correct the deficiency through training of staff, purchasing different products, and setting a schedule for pulling items to be thawed. The facility will train for all types of frozen items – breads, meats, fruits etc. and the safe procedure for each type of food.	

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F 371	Continued From page 25 of dessert topping floated on the water. At approximately 11:55 a.m. a staff person began running water into the stockpot. As the pot filled with water, the dessert topping remained almost entirely out of the water as it floated to the top of the stockpot. At approximately 12:10 p.m. the staff person removed the dessert topping from the top of the water, opened the plastic package and began garnishing the lunch desserts with the topping. On 09/16/13 at approximately 12:50 p.m. Staff Member H, a Contract-Dietary Manager, stated they usually thaw food in the refrigerator but sometimes they thaw under running water. She stated the cook who was thawing the meat knew he should have had water running over the meat. When informed about the raw ground beef not being completely immersed under running water, she acknowledged this was not a good practice, and stated she would "inservice staff on keeping food products under running water when thawing." STORING OF WIPING CLOTHS BETWEEN USES: On 09/10/13 at 8:50 a.m. two wiping cloths were on the counter near the hand washing sink. They were soiled and wadded up. They were dry to touch. In a nearby food preparation sink, a green bucket was observed with sudsy appearing liquid in the bucket. A rag was in the green bucket, immersed in the liquid. On 09/16/13 at 11:25 a.m., Staff Member H stated the wiping cloths used for equipment and food preparation surfaces were to be kept in soapy water. She stated they did not store the	F 371	Training: Dietary management reviewed individually with each cook and assistant the safe procedures for thawing as soon as the survey arrived. It was also reviewed again at a kitchen staff meeting on October 3, 2013 with both discussion and a handout from the food workers booklet describing safe thawing methods. Purchasing: Frozen products will be purchased in sizes that can be completely immersed in running water in the event that is needed; ground round is being purchased in 5 lb. chubs instead of 10 lb. Scheduling: the cooks will have a weekly schedule document to remind them when to pull frozen items. This will begin on October 15, 2013 and will be written out for the cooks weekly. Corrective action will be completed on October 20, 2013 Dietary Management monitor continued compliance Response to F-371: CCC State Health Survey of September 17, 2013 **Storing of Wiping Cloths between Uses:** The licensor saw two wiping cloths on the counter by the hand washing sink.	

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F 371	Continued From page 26 cloths in sanitizer between uses because the chemical sanitizer was too hard on the cloth.	F 371	The laundry buckets for the cloths are underneath the hand washing sinks.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe environment was provided in the outside patio/lawn area for resident use. The wooden cover for a well-like structure was in disrepair with the potential for residents to fall through. Also, the lawn was uneven with a potential for resident falls. Further, the laundry ventilation/cooling system was not being maintained in a safe and clean manner. This placed the residents at risk of medical complications due to inhalation of air-borne particles. Findings include: On 09/17/13, the Maintenance Director, Staff Member T lifted the wooden lid from a approximately four feet square wooden structure. The top of the lid sagged in the middle. The structure covered a water system which drained from the laundry underground to the septic system. When raised, the wood which the cover rested upon was moist and decaying. The cover itself was also damp and decaying with one of the wooden boards broken. The ground surrounding the wooden structure	F 465	Those soiled dry cloths would not have been reused and were meant to be put in the laundry bucket under the hand washing sink. Also, the facility does not store its wiping cloths in the sanitizer because we do not apply sanitizer with a cloth. The facility uses the green bucket system by San Jamar for the cleaning of counters first and then spray sanitizing. The San Jamar system uses a combination green bucket cleaning (soapy degreaser) with a spray bottle of sanitizer. The wiping rags are kept in the sudsy solution as they are used for cleaning and removing of debris and oils. After rinsing, the sanitizer is sprayed on the surface and allowed to air dry. Also to clarify my comment in the survey: wiping cloths stored in sanitizer weaken the sanitizer much faster as the sanitizer attacks the fibers in the cloth. The concern is not the cloth but the weakening of the chemical sanitizer. According to Ecolab putting the sanitizer in a spray bottle allows the sanitizer to maintain its strength significantly longer. **POC:** The kitchen will properly maintain its wiping cloths to provide a clean and sanitary work space for the preparation of food.	

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F 465	Continued From page 27 was uneven with holes that were not noticeable as they were covered by grass. The lawn area was also uneven with the potential for falls if an unstable resident attempted walking on it. When interviewed on 09/17/13 at approximately 1:00 p.m., a support staff member stated she accompanied the residents with cognitive impairment outside when they wanted to go as the lawn could cause a fall. She stated the residents could not go out without someone in attendance. Multiple doors accessed the lawn/patio area for residents to enter the outdoor space. Additionally, the ventilation/cooling system (swamp cooler) in the laundry was soiled with dust, lint and grime that potentially caused poor functioning of the unit and/or spread of dust into the environment. The door to the laundry was opened to the hallway where residents frequented. Further, the ceiling area surrounding the ventilation/cooling system was deteriorating and crumbling around the edges.	F 465	The staff will make sure that soiled wiping cloths go directly into the laundry buckets stored by the hand washing sinks and staff will be reminded not to leave them on the counter by the area where the bucket is stored. If the bucket is missing, they will replace it. The kitchen employees have been individually reminded not to leave dish rags on the counter. It was reviewed at the October 3, 2013 kitchen staff meeting. It will be gone over again at the October 17, 2013 kitchen staff meeting. Staff will monitor and remind each other not to leave a wiping cloth on the counter but put it in either the soapy green bucket or the laundry bucket. Corrective action completed on October 17, 2013. Dietary Management monitor continued compliance	
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a pest	F 469	F-465 Comfortable environment 1. Laundry ventilation/cooling system has been cleaned and repaired. The maintenance department will monitor monthly to assure continued	

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F 469	Continued From page 28 program with measures to eradicate and contain common household pests that included monitoring for pests. This caused pests that included millipedes, spiders, and ants to remain in the facility rather than being eradicated. Findings include: On 09/10/13, the common women's bathroom across from the main dining room had a millipede crawling across the floor. When the housekeeper was asked about it, she stated she had recently observed another one down the 200 hallway. Resident #29. On 09/10/13 at 11:00 a.m., she was being interviewed in her room when she pointed to a bug crawling on the window ledge from below the window air conditioner. She asked that the bug be removed. The window air conditioner was noted sealed by duct tape around the edges which had gaps to the outside. The resident stated she had a spider in her room recently and ants in her bathroom about a week ago. On 09/10/13, Staff Member T, the maintenance supervisor, stated the bug from Resident #29's room was a millipede. He stated they make their way into the building at times and were "a seasonal thing." He said a company did spray for them. When interviewed on 09/11/13, a person not associated with the facility stated that s/he had visited Resident #29 this week and observed a very large spider on the ceiling. On 09/12/13 at 1:00 p.m., Resident #29 stated she saw a large spider crawling out from under her bed the evening before while she was	F 469	compliance. Corrected 10/18/2013 2. Wooden structure covering laundry drain system in poor repair. The wooden structure will be rebuilt with new materials and the ground around the edges will be level to illuminate uneven ground. New materials have been purchased and are on site. The Maintenance Supervisor will complete this project and maintain its safety. Corrected 10/25/2013 3. Swamp cooler in laundry soiled with dust, lint and deteriorating and crumbling around the edges has been cleaned and repaired. The maintenance department will monitor monthly to assure continued compliance. Corrected 10/18/2013 F-469 Effective Pest Control Program The facility has evaluated its pest control response with the Maintenance Supervisor and Housekeeping Manager.	

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F 469	Continued From page 29 watching television. On 09/17/13 at 11:00 a.m., Staff Member W, the Housekeeping Supervisor, stated there was a pest control program that consisted of a contracted company spraying for insects and bugs a couple of times during the year. The staff seeing insects, bugs, mice, etc. should notify her so that she or the maintenance supervisor could notify the company. When ask if there was a mechanism for reporting, the houskeeper stated no, but the staff could always fill out a maintenance request slip. Despite a contracted company visiting the facility several times a year, it was insufficient to control pests.	F 469	We have revised our system of communication to improve the coordination and response pest control. The new Maintenance/Housekeeping Alert Request Form is made available throughout the facility. The general staff will be addressed on this change at the general staff meeting scheduled for 10/22/2013. The Maintenance Supervisor will coordinate and supervise the continued compliance of this survey finding. Corrected 10/23/2013	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, interiview and record review, the facility failed to ensure staff could implement fire procedures during an actual fire situation. This placed residents at risk of harm. Findings include: The Disaster Plan for fires directed staff to 1) Remove resident from fire area; 2)Announce 'code red' over address system to alert all staff of	F 518	F-518 Training for emergency procedures/drills The facility has expanded the scope of fire orientation for all new employees. We have developed a Orientation Guide which include the Basic Fire Alarm Rules (R.A.C.E), the fire alarm basic rules for code red, as well as a tour of the facility that's orients new staff to the location of fire pull alarms, fire extinguisher, smoke barriers and a broader understanding of the fire alarm system. A general staff meeting will be held on 10/22/2013 to review the facility guidelines for fire safty and the proper	

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F 518	Continued From page 30 fire location and activate the fire alarm system; 3) Control fire by cloing doors, windows, turning off electrical items; and 4) Evacuate if necessary. The plan also identified staff to keep calm and reassure the residents. At approximately 12:15 a.m. on 9/10/13, the dining room meal was in progress. The activity assistant, Staff Member Q, suddenly entered and ran across the dining room loudly stating "There is a fire outside," and pointing to the patio. A metal unit was noted emiting smoke and flames against the outside wall on the patio. Staff Member T, the maintenance supervisor, took a fire extinguisher and proceeded to the fire site. The North 400 hallway, considered by staff as the specialty unit for those with cognitive impairments, had the fire doors closed. Upon entering through the fire doors, two nursing assistants were directly inside. One stated there was a fire drill. When informed it was not a drill but that there was a fire, Staff Member L, nursing assistant, immediately hurried down the hall telling the other nursing assistant to check each resident room, shut the windows and turn off the electrical equipment. He went to the dining room at the end of the hallway and told the feeding assistant there was an actual fire and to stay with the residents. The dining room at end of the hall had one worker, Staff Member N, who was left in the Vista dining room. She was a 'paid feeding assistant' who would not be able to provide for the residents in an emergency due to her scope of practice. When interviewed on 09/10/13 at 1:00 p.m., Staff Member K, a licensed nurse, said he had not	F 518	procedures for activating the fire alarm. The Assistant Administrator will monitor this survey finding for continue compliance. Corrected 10/22/2013.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505151	A. BUILDING _____ B. WING _____	09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASHMERE CONVALESCENT CENTER	817 PIONEER AVENUE CASHMERE, WA 98815

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F 518	Continued From page 31	F 518		

heard the "Code Red" announcement that should have come over the intercom.

On 9/10/13 at 2:00 p.m., Staff Member L, stated that once he was aware it was an actual fire, he immediately started to shut off electrical items in the residents' rooms and follow fire protocol. He stated he was not aware it was an actual fire until told by the surveyor; he thought it was a drill. He said they had not announced "Code Red" over the intercom that meant it was an acutal fire.

On 09/10/13 at 12:30 p.m., the independent dining room (Pioneer) had mulitple residents, some in wheelchairs, waiting for their meal. However, there was no staff member in the room to ensure the safety of the residents and allay their fears as per the fire protocol.

On 09/10/13 at 2:30 p.m., Staff Member T, Maintenance Supervisor, stated a Licensed Nurse pulled the alarm at the nurse's station. Staff Member Q from activities saw the fire when going outside to the garbage receptacle and had then ran through the dining room to alert staff of the outside fire. He stated anyone can announce 'Code Red' over the intercom which means someone should pull the fire alarm and complete the "RACE" protocol. That included clearing debris out of the hall and removing residents to behind room fire doors. He stated someone should be with residents at all times if there were residents in a dining area.

On 09/17/13 at 11:00 a.m., Staff Member Z, the charge nurse, was asked her procedure if the fire alarm were to sound. She stated she did not know; was not quite sure as she was new and only had a couple of classes on fire alarms. She

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F 518	Continued From page 32	F 518		

went to find the Fire Disaster Manual but had to ask another staff member where it was located.

When interviewed on 09/17/13 at 2:00 p.m., the activities assistant, Staff Member Q, was asked about fire protocol. She questioned whether it was the fire protocol for inside or outside of the building as they would be different. The fire "the other day" was on the outside and she "knew the walls were fire resistant" so she went to notify people and pull the alarm. However, she could not find the alarm in the hall.

On 09/17/13 at approximately 2:30 p.m., Staff Member T further stated that 'Code Red' was a way to announce the fire for staff without scaring the residents by yelling 'fire'. The staff should act in a manner as if it was an actual fire even if it were a drill. He said fire drills were done monthly on different shifts and he trained new staff upon hire. He also said staff should remain with a large group of residents if they were in a common area, such as a dining room with closed doors.

Although training had been occurring upon hire and monthly, when an actual fire occurred, staff did not correctly implement the fire protocol placing residents at risk of injury during the crisis.